c. **Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

A Prospective Payment System (PPS) consistent with paragraph (15) payment described in section 1902(aa) of the Act for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001 the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100 percent of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act.

Newly qualified FQHCs/RHCs after Federal fiscal year 2010 will have initial payments (interim PPS rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the PPS rate(s) will then be established based on actual cost to provide those services for their first full year. The per visit PPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i) (4) of the Social Security Act, for that calendar year as published in the Federal Register adjusted to take into account any reported change in scope of services, reported and requested during that year. All required documentation of actual costs for the first full year of providing services

must be furnished to DHCFP no later than six (6) months after completion of the first full year of services. If the required documentation is not received within six (6) months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual PPS rate is determined.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. The actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those new services) and an adjustment to the baseline PPS rate will be made.

PPS For Facilities Enrolling After February 6, 2016

Effective February 6, 2016, DHCFP will pay new FQHC's up to 3 service specific visits per patient per day to allow for a medical, mental health and dental visit to occur on a single day for the same patient. The interim Service Specific PPS Encounter rate for mental health services will[LT1] be the current rate established for each FQHC for a medical visit or an amount agreed to between the specific FQHC and DHCFP. After one year of providing up to three visits per patient per day, the payments of the FQHC will be cost settled and any over or under payments will be reconciled and the Service Specific PPS rate will be established. This review of actual costs for each specific service type will be completed by DHCFP or an entity contracted by DHCFP.

Alternative Payment Methodology (APM) Reimbursement

For any fiscal year after FY 2002, a State may use a methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

APM for Medical, Dental, and Behavioral Health Services

Effective for services provided on and after February 6, 2016 enrolled FQHCs previously receiving the single PPS rate may elect to receive payment through an APM that establishes separate PPS rates for medical, dental and behavioral health services. At the providers' request, beginning in 2012, the State reviewed cost data for all applicable services (medical, dental and mental health, where applicable) and service specific PPS rates were developed for each enrolled FQHC for the separate service types being provided. These PPS rates will be adjusted for any change of scope in services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-B

APM to Reflect Other Payment Adjustments

FQHCs/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war[MC2]. However, if an FQHC's/RHC's existing PPS/APM rates are sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/APM rates are not sufficient to cover the additional costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Effective October 1st (FFY) of each year after an APM rate has been established, for services furnished on or after that date, DHCFP will adjust the APM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

Change in Scope of Services

PPS/APM rates will be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the change in scope of services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a change in scope of services was received by DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify the changes.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual new costs for a full year of service and an adjustment will be made to the PPS/APM rate. Adjustments to the PPS/APM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based on a provider's audited and approved costs for the change in scope of services. The PPS/APM rate adjustment will then be determined by dividing the allocated costs by the number of total visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service ~~covered Medicaid services (covered under the Medicaid State Plan and approved by CMS) that~~ meets the definition of FQHC/RHC services as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/APM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements [MC3]:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in section 1905 (a) (2) (B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards [MC4] and/or 42 CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC's/RHC's per visit PPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHCs/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental, behavioral health) of all sites that provide that specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A **Change in Scope of Services** includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/APM rate or the establishment of a new PPS rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the amount of services offered, i.e., previously only offered dental cleaning and exams/x-rays and now offering more advanced services such as root canals or extractions. Simply providing more visits of the same service type does not constitute a change in scope.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase is denied, the provider may request a formal rate appeal from DHCP. Refer to Medicaid Service Manual (MSM) Chapter 700 for details on Rate Appeals.

Definition of a Visit/Encounter

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/APM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, ~~Certified Registered Nurse Anesthetist~~, Certified Nurse Midwife[MC5], Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist[MC6].

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- ~~HRSA Notice of Awards for all approved Changes in Scope of Services~~[MC7]
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payor
- Other Items as Deemed Necessary

Record keeping and Auditing

All participating FQHCs/RHC~~'~~s shall maintain an accounting system, which identifies costs in a manner that conforms to generally accepted accounting principles and must ~~maintain documentation~~maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation

may result in denial of a rate adjustment request.

If a rate adjustment increase is denied, the provider may request a formal Rate Appeal from DHCFP. Refer to Medicaid Service Manual (MSM) Chapter 700 for details on Rate Appeals.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with MCEs

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS or APM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/APM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to DHCFP. ~~The~~ FQHCs/RHCs must provide sufficient documentation (as requested) to DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an electronic request for supplemental payment, which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid, and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than thirty days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.